17. ODHS 2524, Attachments 4 and 5

The allocation bases which are to be used and the cost centers which are to be combined for allocation are optional. Any allocation methodology employed, as well as subsequent alterations of said methodology, must be approved at audit by the ODHS. The ODHS 2524 attachments 4 and 5 are provided solely for the convenience of the provider. This is not the only method that is allowable, but rather one of many appropriate methods which may be utilized.

The cost-finding methodology provides for allocating general service cost directly to revenue-producing and nonreimbursable cost centers. Attachment 4 provides the statistics necessary to allocate general service cost to the revenue-producing and nonreimbursable cost centers on Attachment 5.

On ODHS 2524 Attachment 4, columns 1 through 5, line 14, and ODHS 2524, Attachment 5, columns 2 through 7, line 1, enter general service costs to be allocated which are obtained from ODHS 2524, Schedules B, C, and D, column 5 as follows:

	From ODHS 2524 Schedules B, C, D Column 5	To ODHS 2524 Attachment 4 Line 14	To ODHS 2524 Attachment 5 line 1
Housekeeping Operation and Maintenance of Plant	Sum of Schedule C Lines 10-12 and Schedule B Lines 67 and 71	Column 1	Column 2
Cost of Ownership and Renovations	Sum of Schedule D Lines 10 and 23	Column 2	Column3
Dietary	Schedule B Sum of Lines 9 and 61	Column3	Column 4
Routine Therapy and Nursing	Schedule B Sum of Lines 12,13,18,28, 60 and 62	Column 4	Column 5
Other General Service Cost	Sum of Schedule C Lines 1-9 and 13-29	Column 5	Column 7

Attachment 5, column 1, line 1 — Enter total of columns 2 through 7, line 1.

Attachment 5, column 1, lines 2 through 12 — Enter direct costs of revenue producing nonreimbursable cost centers which are obtained from ODHS 2524, Schedules B and C, column 5, as follows:

Other Nonreimbursable	From ODHS 2524 Schedule B & C, Column 5	To ODHS 2524 Attachment 5 Column 1
Radiology	Schedule B, Line 74	Line 2
Laboratory	Schedule B, Line 75	Line 3
Oxygen	Schedule B, Line 76	Line 4
Legend Drugs	Schedule B, Line 73	Line 5
Other	Schedule B, Line 77	Line 6
Other Nonreimbursable	Schedule C, Line 42	Line 12

Attachment 4, columns 1 through 4, lines 2 through 12 — Enter statistical allocation basis by which expenses of general service cost centers are to be allotted. Enter on line 13, columns 1 through 4, the sums of lines 2 through 12. The statistical bases used in each column should reflect only those statistics applicable to the revenue-producing and nonreimbursable cost centers; do not include any routine service cost center statistics. The bases of allocation are as follows:

Column	General Service Costs	Allocation Bases
1	Housekeeping and Plant Operations	Square feet
2	Cost of Ownership	Square feet
3	Dietary	Meals
4	Routine Therapy & Nursing Services	Hours of Service

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Attachment 4, columns 1 through 4, line 15 — Determine the "unit cost multiplier" by dividing the amount on line 14 by the amount on line 13.

From Attachment 4 — Multiply the appropriate unit cost multipliers from line 15 by individual cost center statistics in columns 1 through 4. Enter resulting amounts in appropriate columns and lines in Attachment 5.

Attachment 5, columns 2 through 5 — Enter on line 13 the sum of amounts computed on lines 2 through 12. For each column the amount on line 13 must equal the amount on line 1.

Attachment 5, column 6, lines 2 through 12 — Enter the sum of columns 1 through 5.

Attachment 5, column 6, line 13 — Enter the sum of lines 2 through 12. This total plus the amount in column 7, line 1, must equal the amount in column 1, line 13.

Transfer amounts on Attachment 5, column 6, lines 2 through 6 and lines 11 through 13 to Attachment 4, column 5, lines 2 through 6 and 11 through 13. For Attachment 4, column 5, line 9, enter the sum of Attachment 5, column 6, lines 8 and 9.

Attachment 4, column 5, line 15 — Determine the unit cost multiplier by dividing the amount on line 14 by the amount on line 13.

Attachment 4 — Multiply unit cost multiplier, line 15, by individual cost center amounts in column 5. Enter the resulting amounts on Attachment 5, column 7, lines 2 through 12. Line 13 is the sum of lines 2 through 12.

Attachment 5, column 8, lines 2 through 12—Enter the sum of columns 6 and 7.

Attachment 5, column 8, line 13—Enter the sum of lines 2 through 12. The amount on line 13 must equal the amount in column 1, line 13.

3. **ODHS 2524, Schedule B, C, D, Columns 7 and 8**
   Column 7

   (1) **Ratio for Reference 2** — Divide allowable indirect cost on ODHS 2524, Attachment 5, column 2, line 9, by total in column 2, line 13, to determine ratio of allocation, line 14.
   Enter ratio on ODHS 2524, Schedules B and C, column 7 (Ratio of Allocation);
   Schedule C, lines 10-12; Schedule B, lines 64-66 and 68-70 (indicated by the digit "2" in reference column).

   (2) **Ratio for Reference 3** — Divide allowable indirect cost on ODHS 2524, Attachment 5, column 3, line 9, by total in column 3, line 13, to determine ratio of allocation, line 14. Enter ratio on ODHS 2524, Schedule D, column 7 lines 1-9, 11-22 (indicated by digit "3" in reference column).

   (3) **Ratio for Reference 4** — Divide allowable direct cost on ODHS 2524, Attachment 5, column 4, line 8, by total in column 4,line 13, to determine ratio of allocation, line 14. Enter ratio on ODHS 2524, Schedule B, column 7, lines reference column).

   (4) **Ratio for Reference 5** — Divide allowable direct cost on ODHS 2524, Attachment 5, column 5, line 8, by total in column 5, line 13, to determine ratio of allocation, line 14. Enter ratio on ODHS 2524, Schedule B, column 7, lines 10 and 11, 13 through 17 , 31 through 41, 43 through 58, and 62 (indicated by digit "5" in reference column).

   (5) **Ratio for Reference 7** — Divide allowable indirect cost on ODHS 2524, Attachment 5 column 7, line 9, by total in column 7, line 13, to determine ratio of allocation, line 14. Enter ratio on ODHS 2524, Schedule C, column 7, lines 1-9 and 13-26 (indicated by digit "7" in reference column).

Column 8

(1) **ODHS 2524, Schedules B, C, and D** — Multiply column 5 by the corresponding ratio of allocation in column 7; enter result in column 8.

(2) **ODHS 2524, Schedule B, column 8** — Enter any ancillary expenses from ODHS 2524, Attachment 5, as follows:

Other Nonreimbursable	From ODHS 2524 Attachment 5, Column 8	To ODHS 2524 Schedule B, Column 8
Radiology	Line 2	Line 74
Laboratory	Line 3	Line 75
Oxygen	Line 4	Line 76
Legend Drugs	Line 5	Line 73
Other	Line 6	Line 77
Other Nonreimbursable	Line 12	Line 78

19. ODHS 2524, Schedule E

Enter balances recorded in the facility's books of accounts at the beginning of the reporting period. Where the LTCF is a distinct part of an institution, enter total amounts applicable to the distinct part. Attachments may be used if lines on the schedule are not sufficient. As stated, amounts entered in columns 1 and 2 are obtained from the provider's books of accounts. Some of these amounts may need to be adjusted. Some examples of accounts which might need adjustments are as follows:

Line 3 — Accounts Receivable: Accounts receivable entered in column 1 represent total amounts expected to be realized by the provider for services and/or supplies sold.

Line 11 — Short -Term Investments: These are temporary investments of operating funds. Operating funds invested for long periods of time would be considered in excess of patient care needs and recorded on line 19.

Lines 14 through 17 — Property, Plant, and Equipment: Amount entered in column 1 should be based on historical cost of the assets or, in a case of a donated asset, fair market value at the time of donation as specified by HCFA Pub. 15-1.

Lines 36 and 37 — "Interest-bearing loans" refers to loans bearing reimbursable interest. "Noninterest-bearing loans" refers to loans bearing interest which is not reimbursable under Medicaid as such interest is considered as investment capital.

20. ODHS 2524, Schedule E — 1

Schedule E-1 is provided for computing reimbursable equity, the average equity capital amount, and the amount of return includable in allowable costs. This schedule must be completed by all for profit homes.

Page 1 of 1

Lines 1 through 16 calculate equity reimbursable under Medicaid regulations.

Line 1 — Must equal Schedule E, line 41.

Line 2 — Must equal Schedule E, line 37.

Lines 6 through 15 — Must specifically identify any amounts entered. Examples of amounts which may be included on these lines are (1) loans to owners or officers and (2) intercompany accounts.

Page 2 of 2

Lines 17 through 23:

Column 1 — List each month included in the reporting period. No more than 6 months should be reflected in the computation for any period.

Column 2 — Enter the equity capital as of the beginning of the reporting period, as computed on ODHS 2524, Schedule E-1 line 16, column 1. This amount will be the same for all months during the period.

Column 3 — List on a monthly basis capital investments made during the period. Capital investments include cash and other property contributed by owners and proceeds from the issuance of corporate stock. Do not include loans from owners. The amount entered on the appropriate line in column 3 is carried forward to subsequent months in the period and is increased by additional contributions in the month(s) in which such contributions are made.

Column 4 — Enter net gain or loss from the disposition of assets. This column indicates the cumulative amount for the period.

Column 5 — Enter amounts withdrawn by owners or disbursed for the personal benefit of owners as well as amounts paid as dividends to corporate stockholders This column indicates the cumulative amount for the period, e.g., if withdrawals occur at the rate of $600 per month, the first month of the period will show $600, the second month $1200, etc. However, if withdrawals are made and are reflected in the profit or loss for the period, e.g., salaries, the withdrawals should not be entered in this column.

Column 6 — Enter other changes in equity capital such as loans from owners (increases) and repayments of same (decreases). Unrestricted donations and contributions are also entered in this column. Refer to HCFA 15-1 Section 1210(A). Beginning with the first month in which a transaction occurs, the applicable amount is carried forward to subsequent months and is increased by additional loans or decreased by repayment of loans.

Column 7 — Equity capital increases or decreases as income is earned or as losses are incurred by the provider during the reporting period. The net amount of change in equity capital from this category of transactions is determined by analyzing the difference between equity capital at the beginning of the period and equity capital at the end of the period. From this net increase or decrease in equity capital are subtracted the amounts included under the other categories of changes on Schedule E-1, column 3 through 6. The remainder represents the increase or decrease due to operations; however, any amount for a return on equity capital included in the interim payments is further subtracted from this remainder. The increase or decrease due to operations is considered as earned uniformly during each of the months of the reporting period and affects equity capital cumulatively. For example, if the net increase due to profits in operations for 6 months is $24,000, $4,000 would be shown in the first month, $8,000 in the second month, etc.

Column 8 — Enter net total of columns 2 through 7. If a negative amount is claimed, enter zero. Add the individual months' equity capital and indicate the total on line 23. The total on line 23 shall include positive monthly balances.

Line 24 — Return on Equity:

Column 1 — Enter amount from Schedule E-1, Line 23, column 8.

Column 2 — Enter number of months in reporting period.

Column 3 — The rate of return used is an estimate based on the Commerce Clearing House Table of Interest Rates 5782 issued in July 1991 and will be revised upon issuance of the appropriate update of the above publication. This is only an estimated rate of return and as such the resulting per diem should be used for budgeting purposes only.

Column 4 — Enter allowable property ownership days from Schedule A, line 6.2.

Column 5 — Enter result of the previous calculation or $1.00, whichever is less.

21. ODHS 2524, Schedule A-3

Column 2 — Those LTCFs which provide only routine services should use the amounts from ODHS 2524, Schedules B, C, and D, column 5. Those LTCFs which have allocated costs or have other nonreimbursable cost centers should use the amounts from Schedules B, C, and D, column 8.

Column 3 — Enter totals as indicated on form.

Column 5 — Calculate per diems for each cost category. The resulting total per diem can be used for budgeting purposes and can be compared to the previous per diem for an estimated per diem charge. This rate does not reflect the payment to be made by Medicaid and is to be used for budgeting purposes only.

The lower portion of Schedule A-3 is provided as a reconciliation of costs as reported in the cost report. The amounts for columns 1 through 4 for lines 29 through 31 are transferred directly from Schedules B, C, and D. On line 32 enter the sum of lines 29 through 31. Enter on line 33, column 4, the total nonreimbursable costs as reported on Schedule B, line 78 and Schedule C, line 42. Deduct line 33 from line 32, column 4, to arrive at the Total Reimbursable on line 34.

22. ODHS 2524, Attachment 3

Attach one copy of the documents listed and attach this form to one copy of the cost report.
Providers who submitted depreciation schedules with the1986 - 1992 cost reports are required to attach only an update on additions or disposition of depreciable assets. New providers who came on the program during the last six months of 1992 must attach detailed depreciation schedules.

23. ODHS 2524, Attachment 8

Complete Attachment 8 to provide necessary information to administer the overpayment recoupment fund.

24. ODHS 2524, Schedule F, Certification

All cost reports submitted by an LTCF must contain a completed certification signed by an administrator, owner, or responsible officer of the facility. Original signature must be notarized. Any subject not covered in this set of instructions is located in OAC Rules 5101:3-1-49 through 5101:3-3-52.

1992 MEDICAID COST REPORT
Long-Term Care Facility

This cost report must be received or postmarked by March 31, 1993 except state operated ICFs-MR pursuant to OAC Section 5101-3-3-26. Failure to file timely will result in reduction in rate by two dollars ($2.00) per patient day pursuant to OAC Rule 5101:3-3-171. Read instructions before completing the form. Please round to the nearest dollar for all entries made on this cost report. When completed, mail two copies to Ohio Department of Human Services, Bureau of Long-Term Care, Audits and Reimbursement Section, 30 East Broad Street, 33 Floor, Columbus, Ohio 43266-0423.

Name of Facility	Medicaid Provider Number	Medicare Provider Number
Address	Federal ID Number	Period Covered by Cost Report From:
	County	Through:

TYPE OF CONTROL

Proprietary for Profit	Voluntary Nonprofit
☐ 1.1 Individual ☐ 1.2 Partnership ☐ 1.3 Corporation-Name & Address: _____ ☐ 1.4 Other: _____	☐ 2.1 Church ☐ 2.2 Other: _____ ☐ 2.3 Church Corporation
Nonfederal Government	**Name and Address of Owner of Real Estate**
☐ 3.1 State ☐ 3.2 County ☐ 3.3 City ☐ 3.4 City-County ☐ 3.5 Hospital ☐ 3.6 Other: _____	

TYPE OF FACILITY

In 7/1/92 through 12/31/92	Is Facility a Unit of a:	Name and Address of Owner(Operator) of Business
☐ 1. Nursing Facility ☐ 2. ICF-MR Facility	☐ a. Hospital ☐ b. Rehabilitation Center ☐ c. Other: _____	

ALL PATIENTS	Distinct Part Medicaid Certified Only *(if applicable)*	Total of Facility
1. Licensed beds at beginning of period _____		
2. Licensed beds at end of period _____		
3. Total bed days available _____		
4. Total inpatient days _____		
5. Percentage of occupancy (line 4 divided by line 3) _____		
*6.1 Administrative and General allowable days (greater of line 4 or .85 X line 3)		
*6.2 Property Ownership allowable days (greater of line 4 or .95 X line 3)		

OHIO MEDICAID ASSISTANCE PROGRAM PATIENTS

7. Total patient days (from Schedule A-1, line 9, column 5) _____	
8. Utilization (line 7 divided by line 4) _____	

9. NFs only: During July through December 1992 did you serve ten or less Medicaid recipients at all times? Yes ☐ No ☐

*EXCEPT AS PROVIDED IN OAC RULE 5101-3-3-171.

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SUMMARY OF INPATIENT DAYS

Name of Facility	Medicaid Provider Number	Reporting Period From: Through:

Note: All data must be stated on a service date (accrual) basis. For example, July data would include only the applicable days and billings for services rendered during July.

Month	Number of Medicaid Certified Beds (1)	Patient Days (Per Census) for Medicaid Patients Only: Authorized Days (2)	Hospital Leave Days* (3)	Therapeutic Leave Days* (4)	Total Medicaid Days (sum of col. 2-4) (5)	Non-Medicaid Eligible Patients: Private Days (6)	Medicare Days (7)	Veterans and Other Days (8)	Inpatient Days for Patients (sum of col. 5-8) (9)
1. July									
2. August									
3. September									
4. TOTAL 3rd QTR (sum of lines 1-3)									
October									
6. November									
7. December									
8. TOTAL 4th QTR (sum of line 5-7)									
9. TOTAL all QTRs (sum of line 4 and 8)									
					to ODHS 2524 Schedule A line 7	to ODHS 2524 Schedule A-2 line 12 col . 4	to ODHS 2524 Schedule A-2 line 12 col. 5	to ODHS 2524 Schedule A-2 line 12 col. 6	to ODHS 2524 Schedule A line 4

***CONSULT THE OHIO ADMINISTRATIVE CODE RULE 5101:3-3-03 FOR AN EXPLANATION OF THE DIFFERENCE BETWEEN HOSPITAL AND THERAPEUTIC LEAVE DAYS.**

Effective July 1, 1989, payment for medically necessary leave days and limited absences has changed to 50% of the Medicaid rate for NFs. These facilities must also report each medically necessary leave day and limited absence as 50% of an inpatient day. Please refer to LTCTL 89-5 for details.

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SUMMARY OF MEDICAID DAYS FOR TRANSFERRED BEDS FROM ANOTHER PROVIDER AND BEDS NEW TO THE MEDICAL ASSISTANCE PROGRAM

Name of Facility	Medicaid Provider Number	Reporting Period From: Through:

Note: All data must be stated on a service date (accrual) basis. This schedule is a summary of Schedule A-1 Page 1 of 2 Medicaid days. Total Medicaid days line 9 Column 9 must agree to Schedule A-1 page 1 of 2 line 9 Column 5. **This schedule does not need to be completed unless you have transferred beds from another provider or beds new to the Medical Assistance Program.** Complete a separate Schedule A-1 page 2 of 2 for each occasion beds were transferred from another provider during the cost report period. If beds were transferred or added new to the Medical Assistance Program more than once, also submit an additional Schedule A-1 page 2 of 2 to summarize all Medicaid days.

Month	Medicaid Days for Existing Facility (1)	Transferred Beds from Another Provider: Number of Beds Transferred (2)	Medicaid Days (3)	Date Transferred (4)	Previous Provider Number (5)	Previous Provider Rate (6)	Beds New to Medical Assistance Program: Number of New Beds (7)	Medicaid Days (8)	Total Medicaid days (sum of col. 1,3 & 8) (9)
1. July									
2. August									
3. September									
4. TOTAL 3rd QTR (sum of line 1-3)									
5. October									
6. November									
7. December									
8. TOTAL 4th QTR (sum of line 5-7)									
9. TOTAL all QTRs (sum of line 4 & 8)									

To ODHS 2524 Schedule A-1, P.1 of 1, col. 5, line 9

THIS SCHEDULE DOES NOT NEED TO BE COMPLETED UNLESS YOU HAVE TRANSFERRED BEDS FROM ANOTHER PROVIDER OR BEDS NEW TO THE MEDICAL ASSISTANCE PROGRAM.

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Appendix A
Enacted

Schedule A-2

DETERMINATION OF CUSTOMARY CHARGES FOR ROUTINE SERVICES

Name of Facility	Medicaid Provider Number	Reporting Period From: Through:

Instructions: List gross charges for residents days shown in Schedule A-1 and Attachment 7. Gross charges must be reported from the uniform charge structure that is applicable to all residents.

Description	Medicare Part B Primary Payer is:		Private	Medicare Part A Services	Veteran and Other	Subtotal	Medicaid	Total Revenue
	Medicaid	Other						
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1a Physical Therapy Revenue								
1b Ratio of line 1a col x divided by total on line 1a col 9								100%
2a Occupational Therapy Revenue								
2b Ratio of line 2a col x divided by total on line 2a col 9								100%
3a Speech Therapy Revenue								
3b Ratio of line 3a col x divided by total on line 3a col 9								100%
4a Medical Supplies Revenue - See note #2 below								
4b Ratio of line 4a col x divided by total on line 4a col 9								100%
5a Enteral Feeding Revenue								
5b Ratio of line 5a col x divided by total on line 5a col 9								100%
6a								
6b Ratio of line 6a col x divided by total on line 6a col 9								100%
7. TOTAL (Sum of 1a Through 6a)								
Redistribute Medicare Part B Other (from line 7, col 3)								
9. Room and Board (Accounts 5010,5020,5030, and 5040)								
10. Other Routine Revenue - See note #3 below								
11. TOTAL Revenue (Sum of lines 7, 8, 9 and 10 excluding col 3) Total revenue column 9 must equal revenue reported on Attachment number 1 line 17.								
12. Non-Medicaid Inpatient Days (From Sch. A-1 line 9, columns 6, 7, and 8)								
13. Other Non-Medicaid Paid Leave Days (From Attachment 6)								
14. TOTAL Non-Medicaid Days (Sum of lines 12 and 13)								
15. Customary Charge (Line 11 divided by line 14)								

Note #1: If pursuant to rule 5101:3-3-18 you qualify for exemption from the non-Medicaid pay rate, please check appropriate box below:

- ☐ Public facility
- ☐ Medicaid utilization rate for cost reporting year exceeds ninety percent (reference Schedule A, line 8)

Note #2: Include on line 4a, by payer type, only those charges that are considered billable as ancillary services to Medicare. This line should only include gross charges associated with costs reported on Schedule A-2a, line 2, column 5.

Note #3: Include on line 10, by payer type, only those charges that are considered routine for Medicaid. This line should only include gross charges associated with other routine revenue, excluding revenue included on line 4a above.

Note #4: On lines 1b, 2b, 3b, 4b, 5b, and 6b, the "x" refers to the applicable column.

FACILITIES MUST COMPLETE THIS SCHEDULE EVEN THOUGH YOU MAY QUALIFY FOR AN EXEMPTION UNDER NOTE #1.

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DETERMINATION OF MEDICARE PART B COSTS TO OFFSET

Name of Facility	Medicaid Provider Number	Reporting Period From: Through:

Description	Physical Therapy	Occupational Therapy	Speech Therapy	Medical Supplies	Enteral Feeding	Other	Total
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
SECTION A: DIRECT CARE COSTS							
1. Ratio of Medicare Part B Charges where the primary payer is Medicaid (from Sch A-2, col 2, applicable line b)							
2. Direct care costs (from Schedule B column 3)							
3. Direct costs to be offset (line 1 times line 2) costs per applicable cost report line on Schedule B, column 4							
	Physical Therapy Department	**Occupational Therapy Department**	**Speech Therapy Department**	**Medical Supplies Department**	**Other Departments**	**Other Buildings**	**Total**
SECTION B: OWNERSHIP COSTS							
4. Square footage per department - if applicable							
5. Ratio of square footage (line 4, applicable column divided by column 8)							100%
6. Line 1 times line 5							
Costs of ownership (Schedule D line 10 column 3)							
8. Ownership costs to be offset (line 6 times line 7) offset costs on Schedule D line 1 column 4							
9. Renovation costs (Schedule D line 23 column 3)							
10. Renovation costs to be offset (line 6 times line 9) offset costs on Schedule D line 22 column 4)							
SECTION C: INDIRECT COST- ADMINISTRATIVE & GENERAL							
11. Administrative costs (Schedule C line 30 column 3 less Schedule C lines 10,11,12, and 13 column 3)							
12. Total costs (total of Sch. B line 72 col. 3, Sch. C line 30 col. 3, Sch. D lines 10 and 23 col. 3)							
13. Line 11 divided by line 12							
14. Direct costs offset (from line 3 column 8 above)							
15. Administrative cost to be offset (line 13 times line 14) offset costs on Schedule C line 29 column 4							

THE FOLLOWING MEDICAL SUPPLIES WORK SHEET IS NECESSARY FOR COMPLETION OF THE ABOVE SCHEDULE.

DESCRIPTION	COST
Medical supplies nonbillable to Medicare	
Medical supplies billable to Medicare (Schedule A-2a line 2 column 5)	
Enteral feeding expenses (Schedule A-2a line 2 column 6)	
TOTAL medical supplies (must equal Schedule B line 10 column 3)	

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